STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE OF NEED

Nursing Home Related Projects

HOSPITAL BASED PROJECTS

Certificate of Need applications must be submitted with a fee in accordance with WAC 440-44-030 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 RCW and Rules and Regulations adopted by the Department (WAC 248-19). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

APPLICANT(S)

OWNER:

Name and Title of Responsible Officer
(**PLEASE PRINT OR TYPE**)
Legal Name of Owner:

Address of Owner:

Signature of Responsible Officer

Date:_____ Telephone:_____

OPERATOR:

Name and Title of Responsible Officer
(**PLEASE PRINT OR TYPE**)
Legal Name of Operator:

Address of Operator:

Signature of Responsible Officer

Date:_____ Telephone:_____

Type of Ownership:
( ) District
( ) Private Non-Profit
( ) Proprietary - Corporation
( ) Proprietary - Individual
( ) Proprietary - Partnership
( ) State or County

Proprietors or Stockholders information
Provide the name and address of each owner and indicate percentage of ownership:

Operation of Facility:
( ) Owner Operated
( ) Management Contract
( ) Lease

Type of Project (Check all that Apply
( ) Changes in Services
( ) Swing Beds of more than Five
( ) New Facility
( ) Bed Capacity Change/Redistribution
( ) New Institutional Health Service
( ) Capital Expenditure Over Minimum
( ) Other _____

Intended Project Start Date:_____
Intended Project Completion Date:_____
ESTIMATED CAPITAL EXPENDITURE: $_____
Project Description_____

ATTACH NARRATIVE PORTION OF THE APPLICATION

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and one copy of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P O Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health*** for the application review fee, based on the project description, as identified on the **enclosed fee schedule.**

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: $ _____ **(refer to fee schedule)**

APPLICANT NAME: _____

DATE OF SUBMISSION: _____ CHECK NUMBER: _____

CERTIFICATE OF NEED
Fee Schedule

Application Fees
An application for a certificate of need under chapter 246-310 WAC shall include payment of a fee consisting of the following:

- A review fee based on the facility/project type.
- When more than one facility/project type applies to an application, the review fee for each type of facility/project shall be included.

Facility/Project Type	Review Fee
Ambulatory Surgical Centers/Facilities	$10,600
Amendments to Issued Certificates of Need	$6,700
Emergency Review	$4,300
Exemption Requests (Non-Refundable Fee)	
• Continuing Care Retirement Communities (CCRCs)/Health Maintenance Organization (HMOs)	$4,300
• Bed Banking/Conversions	$700
• Determinations of Non-Reviewability	$1,000
• Hospice care center	$900
• Nursing Home Replacement/Renovation Authorizations	$900
• Nursing Home Capital Threshold under RCW 70.38.105(4)(e) (excluding replacement/renovation authorizations)	$900
• Rural Hospital/Rural Health Care Facility	$900
Extensions (Non-Refundable Fee)	
• Bed Banking	$400
• Certificate of Need/Replacement-Renovation Authorization Validity Period	$400
Home Health Agency	$12,800
Hospice Agency	$11,400
Hospital (excluding Transitional Care Units-TCUs, Ambulatory Surgical Center/Facilities, Home Health, Hospice, and Kidney Disease Treatment Centers)	$21,000
Kidney Disease Treatment Centers	$13,000
Nursing Homes (including CCRCs and TCUs)	$24,000

Fees for Amending Pending Applications
The fee for amending a pending certificate of need application-shall be as follows:

- When an amendment to a pending certificate of need application results in the addition of one or more facility/project types the review for each additional facility/project type shall accompany the amendment application;
- When an amendment to a pending certificate of need application results in the removal of one or more facility/project types the department shall refund to the applicant the difference between the review fee previously paid
- When an amendment to a pending certificate of need application results in any other change as identified in WAC 246-310-100, a fee of $1,100 shall accompany the amendment application.

Refunds

- When a certificate of need application is returned by the department in accordance with the provisions of WAC 246-310-090 (2)(b) or (e), the department shall refund 75% of the review fees paid.
- When an applicant submits a written request to withdraw certificate of need application before the beginning of review, the department shall refund 75% of the review fees paid by the applicant.
- When an applicant submits a written request to withdraw certificate of need application after the beginning of review, but before the beginning of the ex parte period the department shall refund 50% of all review fees paid.
- When an applicant submits a written request to withdraw an application after the beginning of the ex parte period the department shall not refund any of the review fees paid.

Prepared 12/2/99
Effective 12/18/99

INSTRUCTIONS FOR COMPLETION OF FINANCIAL RATIOS INFORMATION FOR ALL NURSING HOME PROJECTS

Utilizing the data from the financial statements submitted in the application, calculate the Debt Service Coverage, Current Ratio, Assets Financed by Liabilities Ratio, and the Total Operating Expense to Total Operating Revenue Ratio. The method of calculating these ratios is listed below. Enter the ratio figures in the table on the next page. The normal or expected value for each of these ratios is: Debt Service Ratio 1.5 - 2.0; Current Ratio 1.8 - 2.5; Assets Financed by Liabilities Ratio 0.6 - 0.8, and Total Operating Expense to Total Operating Revenue Ration 1.0. If the project's calculated ratios are outside the normal or expected range, please explain.

METHOD FOR CALCULATING FINANCIAL RATIOS

For each financial or calendar year, as appropriate, calculate the Current Ratio, the Assets Financed by Liabilities Ratio, the Total Operating Expense to Total Operating Revenue Ratio and the Debt Service Coverage Ratio:

RATIO	CALCULATION	LINE ITEMS
Current Ratio	Current Assets / Current Liabilities	Schedule B, Line 14 / Schedule B, Line 50
Assets Financed by Liabilities	(Current Liabilities + Long Term Liabilities) / Total Assets	Schedule B, Line 50 + 60 / Schedule B, Line 39
Total Operating Expense to Total Operating Revenue	Total Operating Expense / Net Operating Revenue	Schedule C, Line 22 / Schedule C, Line 9
Debt Service Coverage	(Net Income + Interest Expense + Depreciation Expense) / (Current Portion of Long-Term Debt + Interest Expense)	Schedule C, Line 28 + Schedule G, Line 160 + 158 / Schedule B, Line 44 + Schedule G, Line 160

WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.78 AND WAC 246-310

APPLICATION INFORMATION INSTRUCTIONS

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 78.38.115 and WAC 246-310-210, 220, 230, 240, 370, and 380.

- The application is to be submitted together with a completed, signed Certificate of Need application face sheet and the appropriate review and processing fee. Please send two copies of the entire application to:

  Department of Health
  Certificate of Need Program
  1112 Southeast Quince
  P O Box 47851
  Olympia, Washington 98504-7851

- Submit a copy of the **Letter of Intent** for this project in the application.

- Please make the narrative information complete and concise. Data sources are to be cited Extensive supporting data, that tends to interrupt the narrative, should be placed in the appendix.

- Please number **ALL** pages.

- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.

- Capital expenditures should not include contingencies. Certificate of Need statutes and regulation allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate is required.

APPLICATION INFORMATION REQUIREMENTS FOR HOSPITAL BASED
NURSING HOME RELATED PROJECTS

I. APPLICANT DESCRIPTION

Note: The term "applicant" for this purpose is defined as any person or individual with a ten percentage or greater financial interest in a partnership or corporation or other comparable legal entity or lessee that engages in any undertaking which is subject to review under provisions of Chapter 70.38 RCW.

A. OWNER DESCRIPTION:

1. Legal Name of Owner

2. Address

3. Provide the following information about each Owner

a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnerships, show relationship to any organizations as defined in Section 405.427 of the Medicare Regulations.

b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnership Division, and provide a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

B. OPERATOR DESCRIPTION

1. Legal Name and address of operating entity (unless same as owner).

a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnership Division, and provide a chart showing organizational relationships to any related organizations as defined in Section 405.427 of the Medicare Regulations.

b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnership Division, and provide a chart showing organizational relationship to any related organization as defined in Section 405.427 of Medicare regulations.

C. Is the applicant currently, or does the applicant propose to be reimbursed for services provided under Titles V, XVIII, and/or Title XIX of the Social Security Act?

D. Name, title, address and telephone number of person to whom questions regarding this application should be directed.

E. Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each out-of-state facility, provide the name, address, phone number and contact person for the entity responsible for the licensing/survey of each facility.

II. FACILITY DESCRIPTION

A. Name and address of the proposed/existing facility.

B. Provide the following information:

	HOSPITAL (ACUTE)	NURSING HOME (SNF/ICF)	BOARDING HOME (Cong.)
Total Number of Beds Currently Licensed	_____	_____	_____
Total Number of Beds Currently Set Up	_____	_____	_____

III. PROJECT DESCRIPTION

NOTE: An amended Certificate of Need shall be required if certain modifications are made to a project for which a Certificate of Need was issued in accordance with WAC 248-19- 450.

A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space, as well as the construction of new facility space. Also specify any unique services being proposed.

B. Type of Project (indicate all that apply):

1. _____ New Facility
2. _____ Total Replacement of Existing Facility
3. _____ Renovation/ Modernization
4. _____ Mandatory Correction of Fire and Life/Safety Deficiencies
5. _____ Expansion/Reduction of Physical Plant

C. Health Services (check all in each column that apply):

Types of Therapy/Support Services		Services Currently	Services Proposed
Physical Therapy	Inpatient	_____	_____
	Outpatient	_____	_____
Speech Therapy	Inpatient	_____	_____
	Outpatient	_____	_____
Occupational Therapy	Inpatient	_____	_____
	Outpatient	_____	_____
Nursing Services	Outpatient	_____	_____
Meals on Wheels	Outpatient	_____	_____
Adult Day Care	Outpatient	_____	_____
Other (Specify)	Outpatient	_____	_____

D. Increase in Total Licensed Beds or Redistribution of Beds Among Facility and Service Categories of Acute Care, Skilled Nursing, Intermediate Care, and Boarding Home Care:

	HOSPITAL (Acute)	NURSING HOME (SNF/ICF)	BOARDING HOME (Cong.)
NUMBER OF CURRENTLY LICENSED BEDS			
Number of Beds to be Added	////////		
Number of Boarding Home Beds to be Converted to SNF/ICF		////////	////////
NUMBER OF BEDS TO BE LICENSED AFTER PROJECT COMPLETION			

E. Indicate if the nursing home would be Medicaid certified.

Yes _____. NO _____.

F. Indicate if the nursing home would be Medicare certified and indicate the number of Medicare certified beds.

Medicare Certified: Yes _____ No_____

Number of Medicare Certified Beds: Currently:_____
Proposed: _____

G. Description of new equipment proposed.

H. Description of equipment to be replaced, including cost of the equipment and salvage value, if any, or disposal or use of the equipment to be replaced.

I. Blue print size schematic drawings to scale of current locations of patient rooms, ancillary departments and support services.

J. Blue print size schematic drawings to scale of proposed locations of patient rooms, support services and ancillary departments clearly differentiating between remodeled areas and new construction.

K. Geographic location of site:

1. Indicate the number of acres in the nursing home site.

Acres _____.

2. Indicate the number of acres in any alternate site for the nursing home.

Acres _____.

3. Indicate if the nursing home site or alternate nursing home site has been acquired.

Yes _____ No _____.

4. Address of site: _____
_____

Address of alternate site _____
_____

5. If the nursing home site or alternate site has not been acquired, explain the current status of site acquisition plans along with proposed time frames.

NOTE: If approved, the Certificate of Need will specify the site and/or alternate site of the nursing home. A change of location of the site authorized by the Certificate of Need may require an amendment to the Certificate of Need.

6. Describe any restrictions on usage of the proposed site and alternate site for the proposed project. Restrictions include, but are not limited to the following:

(a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right of ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) other, please specify.

7. Demonstration of sufficient interest in project site. Provide a copy of one of the following:

(a) Clear legal title to the proposed site; or

(b) A lease for at least five years with options to renew for not less than a total of twenty years; or

(c) A legally enforceable agreement to give such title or such lease in the event a Certificate of Need is issued.

8. Demonstration that the proposed site may be used for the proposed project. Please include a letter from the appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project or a written explanation of why the proposed purpose is exempt.

9. If the project involves construction of 12,000 square feet or more, or construction associated with parking for forty or more vehicles, submit a copy of either an Environmental Impact Statement or a Declaration of Non-Significance from the appropriate governmental authority.

NOTE: Projects involving construction of 12,000 square feet or more, or construction associated with parking for forty or more vehicles, are subject to the requirements of the State Environmental Policy Act (SEPA), Chapter 43.21 C RCW. Under the provisions of WAC 248-06-174(4)(b), the department may not issue a Certificate of Need until the requirements of SEPA have been met.

L. Space Requirements

1. Existing gross square feet. _____

2. Total gross square footage for the proposed addition and the existing facility. _____

3. Proposed new facility gross square footage._____

4. Do the above responses include any shelled-in areas?

Yes _____ No _____

If yes, explain the type of shelled-in space proposed (administration, patient beds, therapy space, etc.)

_____
_____
_____

M. Proposed Timetables for Project Implementation

NOTE: The Certificate of Need Program will use the following timetables in monitoring the applicant's conformance with the issued Certificate of Need. Failure to meet the timetable specified below may be grounds for withdrawal of a Certificate of Need. (WAC 248-19-475(1))

1. Financing

a. Date for obtaining construction financing.
Month _____, Year _____.

b. Date for obtaining permanent financing.
Month _____, Year _____.
c. Date for obtaining funds necessary to undertake the project.
Month _____, Year _____.

2. Design

a. Date for completion and submittal to Consultation and Construction Review Section of preliminary drawings.
Month _____, Year _____.
b. Date for completion and submittal to Consultation and Construction Review Section of final drawings and specifications.
Month _____, Year _____.

3. Construction

a. Date for construction contract award.
Month _____, Year _____.
b. Date for 25 percent completion of construction (25% of the dollar value of the contract in place).
c. Date for 50 percent completion of construction.
Month _____, Year _____.
d. Date for 75 percent completion of construction.
Month _____, Year _____.
e. Date for completion of construction.
Month _____, Year _____.
f. Date for obtaining licensure approval.
Month _____, Year _____.
g. Date for occupancy/offering of service(s).
Month _____, Year _____.

N. As the applicant(s) for this project, describe your experience and expertise in the planning, developing, financing and construction of skilled nursing and intermediate care facilities.

IV. PROJECT RATIONALE

Provide documentation to establish conformance of this project with applicable review criteria.

A. NEED (WAC 248-19-370 and WAC 248-19-373)

1. Identify and analyze the unmet health service need and/or other problems to which this project is directed.

a. Describe the need of the people you plan to serve for the service you propose.

b. If your project is in the Puget Sound Health Service Area, please address all the applicable standards in the Health Systems Plan.

2. If your proposal exceeds the number of beds identified as needed in your county nursing home planning area, as shown in WAC 248-19-373, please discuss

how the approval of beds beyond the projected need would further the policy that beds should be located reasonably close to the people they serve.

3. Provide utilization data for each of the last three full fiscal years, the current annualized full fiscal year, and the next three full fiscal years: (**USE SCHEDULE A** which is attached to these guidelines.)

4. In the case of any proposed conversion of beds from other service categories to nursing care beds, provide evidence that the conversion will not jeopardize the availability of service. Document the availability and accessibility of the services that are to be converted.

5. In the context of the criteria contained in WAC 248-19-370(2)(a) and (b), please describe how the service will be available to the following: (a) low-income persons; (b) racial and ethnic minorities; (c) women; (d) handicapped persons; (e) elderly; (f) other underserved persons.

6. Does/will your facility require a pre-admission deposit? Please explain the intent and use of the deposit.

7. Please submit copies of the facility's admission agreement, policies and procedures.

8. If you propose any special services including but are not limited to heavy care, Alzheimer's care, respite care and day care.

a. Describe the service in full detail.

b. Include program content, staffing by classification and FTE commitment, budget, and the amount of space dedicated to each service.

c. Document the need for any special services.

9. If the purpose of the project is to correct existing structure, fire and/or life-safety code deficiencies, or licensing, accreditation, or certification standards as provided for under provisions of WAC 248-19-415, provide a detailed description of the cited deficiencies and attach copies of the two most recent Fire Marshal's surveys and/or surveys conducted by the Survey Program, Aging and Adult Services - Nursing Home Affairs or Health Facilities Survey Section, Division of Health, Department of Social and Health Services or other surveying agency.

10. How does the facility define "medically indigent"? What dollar amount of care and percentage of total rate setting revenue did your facility provide to medically indigent patients last year, distinguishing bad debt from charity care?

11. Please indicate the means by which a person can gain access to the facility's services (e.g., physician referral, self admission).

12. Does the facility have any obligation, under any applicable federal regulations to provide uncompensated care, community service, or access by minorities and handicapped persons? If so, please describe how it has fulfilled its requirement(s).

B. FINANCIAL FEASIBILITY (WAC 248-19-380)

APPLICANTS MUST COMPLETE SECTIONS I OR II AND SECTION III.

SECTION I: COMPLETE THIS SECTION REGARDING CALCULATION OF PROPERTY/RETURN ON INVESTMENT RATE IF YOU ARE PROPOSING CONSTRUCTION OF ADDITIONS AT EXISTING NURSING HOMES OF A HOSPITAL OR CONSTRUCTION OF NEW NURSING HOME ADDITIONS.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address and phone number of the licensed architect or engineer that completed this section.

Name: _____
Address: _____
Phone Number: _____

Proposed Site Address _____ Zip Code _____

1. Indicate the total cost of constructing the new nursing home. In cases where a nursing home/hospital facility shares a common foundation and roof, etc., the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall include the following:

a. Land Purchase	$ _____
b. Utilities to Lot Line	$ _____
c. Land Improvements	$ _____
d. Building Purchase	$ _____
e. Residual Value of Replaced Facility	$ _____
f. Building Construction	$ _____
g. Fixed Equipment (which is not included in construction contract)	$ _____
h. Movable Equipment	$ _____
i. Architect and Engineering Fees	$ _____
j. Consulting Fees	$ _____
k. Site Preparation	$ _____
l. Supervision and Inspection of Site	$ _____
m. Costs Associated with Securing the Source(s) of Financing to Include Interim Interest During Construction	
1. Land	$ _____
2. Building	$ _____
3. Equipment	$ _____
4. Other (Itemize)	$ _____
n. Washington State Sales Tax	
1. Land	$ _____
2. Building Costs	$ _____
3. Equipment	$ _____
4. Other (Itemize)	$ _____
o. Other Project Costs - itemize	$ _____
p. Total Estimated Capital Cost (Actual/ Replacement Cost)	$ _____

2. Provide a copy of a signed nonbinding cost estimator's or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n and o above.)

3. Provide a brief description of the contractor's or cost estimator's experience with nursing home projects.

4. Estimated Nursing Home Construction Costs

	Estimated Square Foot	Const. Cost Sq. Ft. (Use (f),(g), & (k) above)	Total Cost/ Bed (Use (p) above)	Total Cost/ Sq.Ft. (Use (p) above)
Nursing Home				

5. For an existing facility, indicate the incremental increase in capital costs per patient day that would result from this project using the chart below:

	Current Year	Year 1	Year 2	Year 3
a. Total Depre. Exp.				
b. Total Interest Exp.				
c. TOTAL CAP. EXP.				
d. Patient Days				
e. Capital Costs/P.D. (c/d)				

SECTION II: COMPLETE THIS SECTION REGARDING DEVELOPMENT OF BUILDING COST PER BED FOR NEW FREE-STANDING NURSING HOMES.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address and phone number of the licensed architect or engineer that completed this section.

Name: _____
Address: _____
Phone Number: _____

Proposed Site Address _____ Zip Code _____

The following Part I, Reasonable Building Cost Guidelines, and Part II, Reasonable Land Cost Guidelines, will be utilized to determine whether or not the building cost per bed and land cost are reasonable. These guidelines are based on WAC 388-96-745.

PART I REASONABLE BUILDING COST GUIDELINES

1. The Marshall Valuation Service (updated January 1986) Section I, pages 5-11, describes the building class (A, B, C, and D) and building quality (excellent, good, average, and low cost) of building. Based on this description, state the building class and building quality that is proposed for construction by this project.

Class _____ Quality _____ Number of Beds ____

2. Indicate the total number of square feet of construction that is proposed including walls, partitions, stairwells, etc.
Total Square Feet _____

3. The Marshall Valuation Service (updated January 1986) Section I, pages 5-11, describes the type of materials that can be utilized to construct the frame, floor, roof, and walls of a building. Based on this description, indicate the type of materials that would be utilized in the following major components of the proposed building.

a. Frame _____
b. Floor _____
c. Roof _____
d. Wall Structures _____
e. Exterior Finish _____
f. Interior Finish _____
g. Lighting, Plumbing & Mechanical _____
h. Heating & Cooling _____

4. Indicate the total cost of constructing the new nursing home. In cases where a nursing home/hospital shares a common foundation and roof, etc., the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall include the following:

a. Land Purchase	$ _____
b. Utilities to Lot Line	$ _____
c. Land Improvements	$ _____
d. Building Purchase	$ _____
e. Residual Value of Replaced Facility	$ _____
f. Building Construction	$ _____
g. Fixed Equipment (which is not included in construction contract)	$ _____
h. Movable Equipment	$ _____
i. Architect and Engineering Fees	$ _____
j. Consulting Fees	$ _____
k. Site Preparation	$ _____
l. Supervision and Inspection of Site	$ _____
m. Costs Associated with Securing the Source(s) of Financing to Include Interim Interest During Construction	
1. Land	$ _____
2. Building	$ _____
3. Equipment	$ _____
4. Other (Itemize)	$ _____
n. Washington State Sales Tax	
1. Land	$ _____
2. Building Costs	$ _____
3. Equipment	$ _____
4. Other (Itemize)	$ _____
o. Other Project Costs - itemize	$ _____
p. Total Estimated Capital Cost (Actual/ Replacement Cost)	$ _____

5. Provide a copy of a signed nonbinding cost estimator's or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n and o above.)

6. Provide a brief description of the contractor's or cost estimator's experience with nursing home projects.

7. The reasonableness of building construction cost is based on the data shown in Table I, Cost Guidelines for New Buildings and Improvements Plus Increments for Additional Beds. Reasonable building costs will be determined by:

a. Locating the class of construction (A, B, C, D) and quality of construction (good, average, low) in Table I, multiply the number of beds proposed by the appropriate per bed base cost;

b. Identify the appropriate Base Cost for the Facility (using the same class and quality of construction) ;

c. Additional incremental allowances are allowed for projects requesting beds between 61-120 and projects of over 120 beds.

c1. For projects greater than 60 beds but less than 121 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds between 60 to 120; OR

c2. For projects greater than 120 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds over 60 but less than 120, then multiply the appropriate incremental allowance by the number of beds over 120 and add these two figures together.

8. The figures from a, b,and c, when applicable, are added to determine the construction cost lids. Final lid values will be adjusted for inflation using the actual change in the appropriate cost indexes.

TABLE I REASONABLE COST GUIDELINES FOR THE NEW BUILDING PLUS INCREMENTS FOR ADDITIONAL BEDS

Class of Construction	Base Cost Per Bed 0 - 60 Constructed	Base Cost Per Bed 61 - 120 Constructed	Base Cost Per Bed Over 120 Constructed	Add to Per-Bed Base Cost for Each Facility	Add for Each Bed Between 60 and 120 Beds	Add for Each Bed Over 120 Beds
A-good	$ 50,139	$ 42,079	$ 39,006	$ 239,773	$ 2,810	$ 1,990
A-average	$ 40,967	$ 34,381	$ 31,870	$ 195,908	$ 2,296	$ 1,626
B-good	$ 48,104	$ 40,371	$ 37,422	$ 230,041	$ 2,696	$ 1,910
B-average	$ 39,786	$ 33,389	$ 30,951	$ 190,261	$ 2,230	$ 1,579
C-good	$ 35,939	$ 30,161	$ 27,959	$ 171,866	$ 2,014	$ 1,427
C-average	$ 27,924	$ 23,435	$ 21,723	$ 133,537	$ 1,565	$ 1,108
C-low	$ 22,019	$ 18,479	$ 17,130	$ 105,299	$ 1,234	$ 874
D-good	$ 32,622	$ 27,377	$ 25,378	$ 156,003	$ 1,828	$ 1,295
D-average	$ 25,221	$ 21,167	$ 19,621	$ 120,612	$ 1,413	$ 1,001
D-low	$ 19,796	$ 16,613	$ 15,400	$ 94,667	$ 1,109	$ 786

9. The above estimated building costs per bed may be adjusted when the following circumstances apply to the project.

a. Construction changes required by the Consultation and Construction Review Section, DSHS, in the course of approving the building plans for the project.

b. Four story or higher construction.

c. Unusual labor or climatic conditions at time of construction that were not foreseeable by management.

d. Cost savings realized in other components of the project such as equipment or operating costs.

e. Where more than one major construction type is present, an average facility type shall be computed by weighing relative cost of the framing, floor, roof, and walls.

Applicants requesting adjustments to the guidelines for reasonable building cost per bed shall provide written justification and a financial analysis showing the rationale for the adjustments.

PART II REASONABLE LAND COST GUIDELINES

1. The land cost guidelines are for land that is utilized by the nursing home service. When an applicant proposes to construct a new nursing home/hospital facility, the amount of land utilized by the nursing home services should be calculated based on Medicaid program methodology for apportioning costs to the nursing home for reimbursement purposes. Based on the above factors, the cost of land plus cost of utilities to lot line for the proposed nursing home would be $ _____.

2. Indicate the number of square feet of land that would be utilized for the nursing home service. _____ square feet.

3. Indicate the cost per square foot for the land utilized by the nursing home service. $ _____.

4. Exceptions to square foot cost lids (WAC 388-96- 745(5)) may be allowed up to a maximum of ten percent (10%) (WAC 388-96-745(6)). An adjustment shall be granted only if requested by the applicant. Applicants requesting adjustments to the guidelines for reasonable land costs shall provide written justification and an analysis showing the rationale for the adjustments.

5. Exceptions to land area lids (WAC 388-96-762) may be allowed. An adjustment shall be granted only if requested by the applicant and meet the criteria defined in WAC 388-96-762(3). Applicants requesting adjustments to the guidelines for area land lids shall provide written justification and an analysis showing the rationale for the adjustments.

Questions regarding the construction cost lid exception process should be directed to the Residential Rates Program of Aging and Adult Services.

SECTION III: ALL APPLICANTS - INTEREST RATE, SOURCE OF FINANCING PROJECT COSTS, ESTIMATED START-UP/INITIAL OPERATING DEFICITS, FINANCIAL STATEMENTS AND PROJECTED PATIENT CHARGES.

1. Identify the owner or operator who will incur the debt for the proposed project.

2. Anticipated Sources and Amounts of Financing for the Project (Actual Sources for Conversions)

	Specify Type	Amount
a. Public Campaign	_____	$ _____
b. Bond Issue	_____	$ _____
c. Commercial Loans	_____	$ _____
d. Government Loans	_____	$ _____
e. Grants	_____	$ _____
f. Bequests & Endorsements	_____	$ _____
g. Private Foundations	_____	$ _____
h. Accumulated Reserves	_____	$ _____
i. Owner's Equity	_____	$ _____
j. Other-Specify	_____	$ _____
k. Total (Must Equal Total Project Cost)	_____	$ _____

3. If the hospital is planning to finance this project from capital allowance, please indicate the amount(s) and the fiscal year(s) during which equity funding would be required.

4. Provide a complete description of the methods of financing which were considered for the proposed project. Discuss the advantages of each method in terms of costs and explain why the specific method(s) to be utilized was (were) selected.

5. Indicate the anticipated interest rate on the loan for constructing the nursing home. _____ %.

6. Indicate if you will have a fixed or a variable interest rate on the long-term loan and indicate the rate of interest.

Fixed interest rate. _____%.

Variable interest rate beginning at _____%
and ending at _____%.

Loan Terms_____

7. Estimated Start-up and Initial Operating Expenses

a. Total Estimated Start-up costs "$" _____ (Expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicaid guidelines for start-up costs.)

b. Estimated Period of Time Necessary for Initial Start- up: _____ "months" (Period of time after construction completed, but prior to receipt of patients.)

c. Total Estimated Initial Operating Deficits "$"_____ (Operating deficits occurring during initial operating period.)

d. Estimated initial operating period _____ "months" (Period of time from receipt of first patient until total revenues equal total expenses.)

8. Evidence of Availability of Financing for the Project

Please submit the following:

a. Copies of letter(s) from lending institution which indicate a willingness to finance the proposed project (both construction and permanent financing). The letter(s) should include:

i. Name of person/entity applying
ii. Purpose of the loan(s)
iii. Proposed interest rate(s) (Fixed or Variable)
iv. Proposed term (period) of the loan(s)
v. Proposed amount of loan(s)

b. Copies of letter(s) from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 8(a) above, as applicable.

c. Copies of each lease or rental agreement related to the proposed project.

d. Separate amortization schedule(s) for each financing arrangement including long-term and any short-term start-up, initial operating deficit loans, and refinancing of the facility's current debt setting forth the following:

i. Principal
ii. Term (number of payment period)
(long-term loans may be annualized)
iii. Interest
iv. Outstanding balance of each payment period

NOTE: ALL TABLES, STATEMENTS, CHARTS, AND COLUMNS USED IN RESPONDING TO THE FOLLOWING INFORMATION REQUIREMENTS SHOULD BE CLEARLY LABELED TO INDICATE THE SOURCE OF DATA USED, AND WHAT THEY ARE MEANT TO CONVEY.

9. Provide a cost center budget showing anticipated revenue, and operating costs during the project and for a three year period following completion of the project, **without inflation, with and without** the project. In the "with" scenario, include start-up costs, and the anticipated period of deficit operations before the project is utilized at a breakeven point.

FOR BASIC SERVICE HOSPITALS (defined for this purpose as those in the "former" peer groups 1 and 2 that continue to submit the short form budget to the Washington State Hospital Commission), provide a cost center budget **without inflation** for the first three years of operation. USE SCHEDULE CC-1 included in these information requirements, adding extra years as needed.

FOR OTHER HOSPITALS, provide a cost center budget without inflation for the first three years of operation. **USE SCHEDULE CC-1** included in these information requirements, adding extra years as needed.

FOR ALL HOSPITALS, provide hospital-wide revenue and expense information. USE **SCHEDULE CC-2**, included in these information requirements. Add extra years to the form as needed to provide a thorough record from the current budget year through the third full fiscal year following completion of the project. Explain any changes from the hospital's current year approved budget. Submit this information **without inflation, with and without** the project. State all assumptions made regarding the Case Mix Index used and calculation of Adjusted Case Mix Value Units.

NOTE: USE SCHEDULES ATTACHED TO THESE GUIDELINES.

10. Provide, in the Washington State Hospital Commission's format, a proforma balance sheet, **without inflation, with and without** the project. This statement shall cover each year starting with the current budget through the third year following project completion. State all assumptions used in projecting the statement. Explain any changes from the balance sheet submitted with the hospital's last budget request.

NOTE: If there are no capital costs associated with this project, no proforma balance sheet is necessary.

11. Provide a capital expenditure budget coverning each year starting with the first year following the last State Hospital Commission budget submittal through the third year following project conmpletion.

12. Calculate the average patient charge rate per day. State all assumptions made for these calculations. The State Hospital Commission will make its determinations on the impact on costs and charges of health care from this data.

13. Provide the following nursing home cost center-specific financial statements through the third complete fiscal year following project completion. Identify all assumptions utilized in preparing the financial statements.

i.	Schedule B	Balance Sheet
ii.	Schedule C	Statement of Operations
iii.	Schedule D	This Statement Has Been Eliminated
iv.	Schedule F	Notes to Financial Statements
v.	Schedule G	Itemized List of Revenue and Expenses
vi.	Schedule H	Debt Information
vii.	Schedule K	Book Value of Allowable Assets

NOTE: USE SCHEDULES ATTACHED TO THESE GUIDELINES.

14. Utilizing the data from the financial statements, calculate the following:

a. Debt Service Coverage
b. Current Ratio
c. Assets Financed by Liabilities
d. Total Operating Expense to Total Operating Revenue Ratio

NOTE: USE FORM ATTACHED TO THESE GUIDELINES.

15. If the project's calculated ratios are outside the normal or expected range, please explain.

16. If a financial feasibility study has been prepared, either by or on behalf of the proponent in relation to this project, please provide a copy of that study.

17. Current and Projected Charges and Percentage of Patient Revenue
a. Per Diem Charges for Nursing Home Patients for Each of the Last Three Fiscal Years:

	19____	19____	19____
Private Pay	_____	_____	_____
Medicaid	_____	_____	_____
Medicare	_____	_____	_____
VA	_____	_____	_____
Other-Specify	_____	_____	_____

b. Current Average Per Diem Charges for Nursing Home Patients:

	Current Year
Private Pay	_____
Medicaid	_____
Medicare	_____
VA	_____
Other-Specify	_____

c. Projected Average Per Diem Charges for Nursing Home Patients for Each of the First Three Years of Operation:

	19____	19____	19____
Private Pay			
Medicaid			
Medicare			
VA			
Other-Specify			

d. Please indicate the percentage of patient revenue that will be received for the :

Existing Facility		Proposed Facility (Expansion)	
Private Pay	____%	Private Pay	____%
Medicaid	____%	Medicaid	____%
Medicare	____%	Medicare	____%
VA	____%	VA	____%
Other-Specify	____%	Other-Specify	____%

C. STRUCTURE AND PROCESS (QUALITY) OF CARE (WAC 248-19-390)

1. Staffing

	Number of Employees Current		Number of Employees Projected	
	Full-time Equivalent	Consultant Hr/Week	Full-time Equivalent	Consultant Hr/Week
Registered Nurses				
LPNs				
Nurses Aides & Asst.				
NURSING TOTAL				
Dietitians				
Aides				
DIETARY TOTAL				
Administrator				
Assistant Admin.				
Administrator In-Train.				
Activities Director				
Medical Director				
Inservice Director				
Director of Nursing				
Clerical				
Housekeeping/Mainten.				
Laundry				
ADMIN. TOTAL				
Physical Therapist				
Occupational Therapist				
Pharmacist				
Medical Records				
Social Worker				
Plant Engineers				
Other (specify categ.)				
ALL OTHERS TOTAL				
TOTAL STAFFING				

2. Nursing Staffing Pattern for Average 24-Hour Day Per Bed Patient

	FTE-Day/ Patient	FTE-Evening/ Patient	FTE-Night Patient
a. Registered Nurses			
b. LPNs			
c. Nurse's Aides & Asst.			
d. Other			

3. Nursing Hours/Patient Day

a. Registered Nurses _____

b. LPNs _____

c. Nurse's Aides & Asst. _____

Total _____

4. Provide evidence which indicates the personnel needed to staff the nursing home will be available.

5. Provide evidence that shows there will be adequate ancillary and support services to provide the necessary patient services.

6. Provide a copy of the facility's Infection Control Policies and Procedures.

7. Explain how the services provided at your facility are integrated with other providers of health services and social services to assure continuity of care is available.

8. Provide evidence which indicates the services provided at your facility will be in compliance with applicable federal and state laws, rules and regulations for health care facilities.

Also, if you plan to be certified under the Medicaid or Medicare program, provide evidence that the project will be in compliance with the applicable conditions of participation related to these programs.

9. The State Health Plan Long Term Care Performance standard 4a(3) states "State approval to build, expand or acquire a nursing home shall not be given to owners or operators of existing nursing homes who, according to federal or this or another state's survey reports for at least the last three years, have had repeated and/or severe violations of standards of patient care." Fully describe any repeated and/or severe violations of standards of patient care for the last three years.

10. Fully describe any history of each applicant with respect to the actions noted in the Certificate of Need criterion, (WAC 248-19-390(5)(a)). If there is such a history, provide evidence that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

11. If applicable, please describe the composition of your facility's community advisory board and its relationship with management of the nursing home facility. Indicate if your existing facility presently has a resident's council or if your proposed new facility will have a resident's council.

12. In the context of the State Health Plan Long-Term Care Performance Standard #4, please document:

a. Evidence of joint planning shall include written agreements with other providers for referral, consultation, and service provision. It shall also include a list of other long-term care services informed about the project including at least the Area Agency on Aging, local home health agencies, the local Community Service Office (CSO) and the local hospitals.

b. Evidence of a commitment to least restrictive placements shall include:

b1) information provided to clients prior to admission on other long-term care services in the community;

b2) the existence of a continuing patient assessment program for all clients regardless of their payment status; and

b3) for existing nursing homes, a documented record of discharging clients to their homes or less intensive services and of maintaining no severe or repeated deficiencies in the discharge planning standard for the last three years. Less intensive services include but are not limited to home health care, adult family homes, and boarding homes. Documentation should identify the number of patients discharged to home and less intensive services during the last three years.

Discharges to Less Intensive Services

	# of patients	% of total #pts
19_____	_____	_____
19_____	_____	_____
19_____	_____	_____

c. For existing nursing homes, evidence of adequate services to maintain client functional independence shall include documentation that for at least the last three years the nursing home has not had repeated and/or severe violations of standards of patient care.

D. COST CONTAINMENT (WAC 248-19-400)

1. Describe distinct alternative means for meeting the need described previously. Identify alternative advantages and disadvantages, including cost, efficiency or effectiveness.

2. Describe, in as much detail as possible, specific efforts that were undertaken to contain the costs of offering the proposed service.

3. In the case of construction, renovation or expansion, describe any operating or capital cost reductions achieved by architectural planning, engineering methods, methods of building design and construction, or energy conservation methods used.

4. Explain how the project will involve improvements on innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

5. Under a concurrent review in accordance with State Health Plan Long-Term Care Performance Standard #5, preference may be given to the project which meets the greatest number of criteria listed below. Provide documentation describing how the proposed project meets the following criteria:

a. Nursing home operators who have the policy of admitting patients without regard to their source of income or payment.

b. Projects that include other institutional long-term care services or evidence relatively greater linkages to community-based long-term care services.

c. Projects which improve the geographic distribution and/or provide access to nursing home beds in a currently underserved area.

d. Nursing home operators having or proposing to have a Medicare contract in areas with less than the statewide proportion of Medicare nursing home beds to total nursing home beds.

e. Nursing home operators serving or proposing to serve Medicaid clients.

f. Nursing home operators proposing to serve additional heavy care patients in areas where CSO placement staff or hospital discharge planners document significant and continuing difficulties in placing heavy care patients in nursing homes.

g. Existing nursing home operators in the state who are seeking to achieve a 100-bed minimum efficient operating size for nursing homes or to otherwise upgrade a facility with substantial physical plant waivers or exceptions, as determined by the State Aging and Adult Services Administration.

h. Projects that propose to serve persons requiring mental health services and persons with dementias.

INSTRUCTIONS FOR COMPLETION TO COST REPORTING
FORMS REQUIRED FOR SUBMISSION OF CERTIFICATE OF
NEED APPLICATIONS FOR NURSING HOME PROJECTS

A complete application for a Certificate of Need will include the information requested in the "Application Information Requirements for Health Care Facility Certificate of Need Applications Nursing Home Related Projects". When completed, the enclosed forms will satisfy the information requirements in the Application Information Requirements under B, Financial Feasibility Section III 13 i, ii, iii, iv, v, except that an application should show start-up costs separately, and should also identify the anticipated period of deficit operations before the project is utilized at a break-even point.

NOTE: ALL FINANCIAL STATEMENTS MUST BE FOR NURSING HOME OPERATIONS ONLY

"NON-INFLATED" PROJECTIONS

All projections for the first through third years of operation shall be shown in **"non-inflated"** dollars based on the last complete fiscal year. **Do not show** increased costs due to anticipated inflationary trends. These "non-inflated" costs **should show** all anticipated costs resulting from increased staffing, supplies, utilities, etc., and should also show anticipated interest expense and depreciation expense.

EXPLANATION OF COLUMN HEADINGS

"Actual" - These columns apply to existing nursing homes proposing the addition of beds or total replacement of an existing facility. "Actual" must be by fiscal year, in accordance with the way books are kept.

"Estimate" - This column applies to existing nursing homes and shall show estimated operational figures for the current twelve months of operation of the facility.

"Projected" - means each twelve months of operation up through at least three full fiscal years following completion of the project.

The dates requested (directly beneath column headings discussed above) refer to the actual dates of the fiscal year for historical data, and the anticipated dates for each fiscal year of operation.

SCHEDULE A

HISTORICAL AND PROJECTED PATIENT UTILIZATION

Name of Facility _____ (NURSING HOME OPERATION ONLY)

Line No.	FISCAL YEAR	Medicare Patient Days	Medicaid Patient Days	Private Patient Days	VA PATIENT DAYS	TOTAL PATIENT DAYS	# OF LICENSED BEDS	OCCUPANCY RATE
1	Actual __/__ to __/__, 19__							
2	Actual __/__ to __/__, 19__							
3	Actual __/__ to __/__, 19__							
4	Estimated __/__ to __/__, 19__							
5	Projected __/__ to __/__, 19__							
6	Projected __/__ to __/__, 19__							
7	Projected __/__ to __/__, 19__							
8	Projected __/__ to __/__, 19__							
9	Projected __/__ to __/__, 19__							

April 1989

SCHEDULE B - BALANCE SHEETS- ASSETS

(in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____ Page 1 of 2

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
1	CURRENT ASSESTS							
2	Cash							
3	Marketable Securities							
4	Patient Accounts Receivable							
5	Other Receivables							
6	Less Allowance for Doubtful Accounts	( )	( )	( )	( )	( )	( )	( )
7	Inventories							
8	Prepaid Expenses							
9	Due from Other Funds							
10	Home Office Current Assets							
11	Patient Trust Fund Assets							
12	Current Interco. Receivables							
13	Other Current Assests							
14	TOTAL CURRENT ASSETS							
15								
16	PROPERTY, PLANT AND EQUIPMENT							
17	Land							
18	Land Improvements							
19	Buildings							
20	Building Improvements							
21	Equipment							
22	Leasehold Improvements							
23	Construction in Process							
24	Home Office Depreciable Assets							
25	TOTAL PROPERTY, PLANT AND EQUIPMENT							
26	Accumulated Depreciation							
27	Accum. Depreciation - Home Office							
28	NET PROPERTY, PLANT AND EQUIPMENT							
29								
30	NON-CURRENT ASSETS							
31	Long-Term Investments							
32	Intercompany Receivables							
33	Unamort. Start-up/Organ. Costs							
34	Goodwill							
35	Home Office Non-Current Assets							
36	Other Non-Current Assets							
37	TOTAL NON-CURRENT ASSETS							
38								
39	TOTAL ASSETS (lines 14 + 28 + 37)							

September 1989

SCHEDULE B - BALANCE SHEETS - LIABILITIES AND EQUITY

(in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICTIONS

FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
40	CURRENT LIABILITIES							
41	Accounts Payable							
42	Notes Payable							
43	Accrued Payroll & Related Liabilities							
44	Current Portion of Long-Term Debt							
45	Due to Other Funds							
46	Home Office Current Liabilities							
47	Patient Trust Fund Liabilities							
48	Current Interco. Payables							
49	Other Current Liabilities							
50	TOTAL CURRENT LIABILITIES							
51								
52	LONG-TERM LIABILITIES							
53	Mortage Payable							
54	Notes Payable							
55	Capitalized Lease Obligations							
56	Intercompany Payables							
57	Deferred Income Tax							
58	Home Office Long-Term Liabilities							
59	Other Long-Term Liabilities							
60	TOTAL LONG-TERM LIABILITIES							
61								
62	EQUITY/FUND BALANCE							
63	Stockholder's Equity							
64	Common Stock							
65	Preferred Stock							
66	Treasury Stock							
67	Additional Paid in Capital							
68	Proprietorship Equity							
69	Partnership Equity							
70	Fund Balance							
71	Retained Earnings							
72	Divisional Equity							
73	TOTAL EQUITY/FUND BALANCE							
74								
75	TOTAL LIABILITIES AND EQUITY							
76	(lines 50 + 60 + 73)							

September 1989

SCHEDULE C - STATEMENT OF OPERATIONS

(in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
1	ROUTINE CARE REVENUE							
2								
3	OTHER PATIENT REVENUE							
4								
5	OTHER OPERATING REVENUE							
6								
7	REVENUE DEDUCTIONS	( )	( )	( )	( )	( )	( )	( )
8								
9	NET OPERATING REVENUE (lines 1+3+5-7)							
10								
11	ROUTINE EXPENSES							
12	Nursing Services							
13	Food							
14	Property							
15	Administration & Operations							
16	TOTAL ROUTINE EXPENSES							
17								
18	OTHER PATIENT EXPENSES							
19								
20	OTHER OPERATING EXPENSES (UNALLOW.)							
21								
22	TOTAL OPERATING EXPENSES(lines 16+18+20)							
23								
24	NON-OPERATING REVENUE							
25								
26	NON-OPERATING EXPENSES							
27								
28	NET INCOME (LOSS)							
29	(lines 9 - 22 + 24 - 26)							

September 1989

SCHEDULE CC--1

COST CENTER REVENUE AND EXPENSE

(in 000's)

Name of Hospital _____

Line No.		WITHOUT PROJECT				WITH PROJECT			
		Current Budget Appr'vd FYE 19___	Projected FYE 19___	Projected FYE 19___	Projected FYE 19___	Current Budget Appr'vd FYE 19___	Projected FYE 19___	Projected FYE 19___	Projected FYE 19___
1	Units of Service								
2	Salaries and Wages •								
3	Employee Benefits								
4	Professional Fees								
5	Supplies								
6	Purchased Services - All								
7	Depreciation, Rental, Lease								
8	Other Direct Expense								
9	Transfers								
10	TOTAL DIRECT EXPENSE								
11	Depreciation, Rental, Lease								
12	Employee Benefits								
13	Central Supplies								
14	Pharmacy								
15	Nursing Float/Transport								
16	SNF/ICF/ATC								
17	Hospital Based Physicians								
18	Recoveries								
19	Other Adjustments								
20	TOTAL RECLASSIFICATION OF EXPENSES								
21	TOTAL ADJUSTED DIRECTED EXPENSE								
22	Cost Allocations								
23	TOTAL OPERATING EXPENSES FOR RATE SETTING								
24	Deductions from Revenue								
25	Capital Allowance								
26	Add'l Other								
27	TOTAL OPERATING EXP., DEDUCTS AND CA								
28	Deduct Other Sources of Revenue								
29	TOTAL EXPENSES FOR SETTING RATES								
30	RATE SETTING REVENUE								
31	NET REVENUE REALIZED								
32	Add Hospital Based Physician Revenue								
33	INPATIENT REVENUE								
34	OUTPATIENT REVENUE								
35	TOTAL GROSS REVENUE								
	Tot.Exp.SettingRates/Units of Service								
	Rate Setting Revenue/Units of Service								

April 1989

SCHEDULE CC--2

HOSPITAL AGGREGATE REVENUE AND EXPENSE

(in 000's)

Name of Hospital _____

Line No.		WITHOUT PROJECT				WITH PROJECT			
		Current Budget Appr'vd FYE 19___	Projected FYE 19___	Projected FYE 19___	Projected FYE 19___	Current Budget Appr'vd FYE 19___	Projected FYE 19___	Projected FYE 19___	Projected FYE 19___
1	Units of Service								
2	Salaries and Wages								
3	Employee Benefits								
4	Professional Fees								
5	Supplies								
6	Purchased Services - All								
7	Depreciation, Rental, Lease								
8	Interest Expense								
9	Other Direct Expense								
10	Transfers								
11	TOTAL DIRECT EXPENSE								
12	Depreciation, Rental, Lease								
13	Employee Benefits								
14	Central Supplies								
15	Pharmacy								
16	Nursing Float/Transport								
17	SNF/ICF/ATC								
18	Hospital Based Physicians								
19	Recoveries								
20	Other Adjustments								
21	TOTAL RECLASSIFICATION OF EXPENSES								
22	TOTAL ADJUSTED DIRECTED EXPENSE								
23	Cost Allocations								
24	TOTAL OPERATING EXPENSES FOR RATE SETTING								
25	Deductions from Revenue								
26	Capital Allowance								
27	Add'l Other								
28	TOTAL OPERATING EXP., DEDUCTS AND CA								
29	Deduct Other Sources of Revenue								
30	TOTAL EXPENSES FOR SETTING RATES								
31	RATE SETTING REVENUE								
32	NET REVENUE REALIZED								
33	Add Hospital Based Physician Revenue								
34	INPATIENT REVENUE								
35	OUTPATIENT REVENUE								
36	TOTAL GROSS REVENUE								
	Tot.Exp.SettingRates/Units of Service								
	Rate Setting Revenue/Units of Service								

SCHEDULE CC-3

Hospital Name _____

Project Title _____

Cost Center Summary

	Without Project			With Project		
	Year 1 19__	Year 2 19__	Year 3 19__	Year 1 19__	Year 2 19__	Year 3 19__
Admissions:						
Hospital Admissions						
Births						
ATC Admissions						
Patient Days:						
Hospital Patient Days						
Newborn Patient Days						
ATC Patient Days						
Skilled Nursing Facility Revenue						
ATC Revenue						
Case Mix Index						
ACMVU						
RSR/ACMVU						

April 1989

SCHEDULE E - STATEMENT OF CHANGES IN EQUITY/FUND BALANCE

(in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

Name of Facility _____ FOLLOWING AASA REPORTING GUIDELINES

Line No.	ACCOUNT	ACTUAL FYE 19____	ACTUAL FYE 19____	ACTUAL FYE 19____	CURRENT FYE 19____	NON-INFLATED DOLLARS PROJECTED FYE 19____	PROJECTED FYE 19____	PROJECTED FYE 19____
1	BEGINNING EQUITY/FUND BALANCES							
2								
3	PROIR PERIOD ADJUSTMENTS (EXPLAIN)							
4								
5								
6								
7								
8	ADJUSTED BEGINNING BALANCE							
9	ADD:							
10	Net Income (loss)							
11	Additional Stock Issues							
12	Additional Paid-in Capital							
13	Other (Explain)							
14								
15								
16								
17								
18	DEDUCT:							
19	Dividends							
20	Partnership Distributions							
21	Owners Draws							
22	Other (Explain)							
23								
24								
25								
26	ENDING EQUITY/FUND BALANCE							

September 1989

SCHEDULE F

NOTES TO FINANCIAL STATEMENTS

(NURSING HOME OPERATION ONLY)

Name of Facility _____

1. Schedules which support account balances should be attached to Schedule G-5.
2. Notes to Financial Statements must include a Schedule of Charges to Private Patients.

REFERENCE Schd. _, line _	

September 1989

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES

REVENUE - (in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

Name of Facility _____ FOLLOWING AASA REPORTING GUIDELINES

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
0	ROUTINE CARE REVENUE							
1	Medicare							
2	Medicaid							
3	Private							
4	Other Routine Care							
5	TOTAL ROUTINE CARE REVENUE							
6	OTHER PATIENT REVENUE							
7	Physician Care							
8								
9	Pharmacy							
10								
11								
12	Nursing Supplies							
13	Equipment Rental							
14								
15	Patient Activities							
16	Laboratory							
17	Exceptional Care							
18	Oxygen							
19	Other Patient Revenue							
20	Mental Retardation							
21	Mental Health							
22	Supplementation							
23	Hold Room							
24	TOTAL OTHER PATIENT REVENUE							
25	OTHER OPERATING REVENUE							
26	Laundry							
27	Meals							
28	Vending Machines							
29	Barber & Beauty Shop							
30	Gift Shop							
31	Patient Telephone							
32	Property Rental							
33	Other Operating							
34	TOTAL OTHER OPERATING REVENUE							
35	NON-OPERATING REVENUE							
36	Gain on Sale of Fixed Assets							
37	Interest Income							
38	Dividend Income							
39	Other Non-Operating							
40	TOTAL NON-OPERATING REVENUE							
41	REVENUE DEDUCTIONS							
42								
43	TOTAL REVENUE (lines 5+24+34+40+41)							

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES
NURSING SERVICES EXPENSES - (in 000's)
(NURSING HOME OPERATION ONLY)
AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS
FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
44	SALARIES & WAGES							
45	DNS							
46	RN							
47	LPN							
48	Nursing Assistants							
49	Other Nursing Services							
50	TOTAL SALARIES & WAGES							
51								
52	FRINGE BENEFITS							
53	PAYROLL TAXES							
54	PURCHASED SERVICES							
55	ALLOCATED EXPENSES							
56	REVENUE OFFSET	( )	( )	( )	( )	( )	( )	( )
57	NURSING SERVICES (lines 50+52+53+54+55+56=57)							

FOOD EXPENSES

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
58	Food							
59								
60	Revenue Offset	( )	( )	( )	( )	( )	( )	( )
61								
62	TOTAL FOOD (lines 58 + 60)							

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES

ADMINISTRATION AND OPERATIONS EXPENSES - (in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

Name of Facility _____ FOLLOWING AASA REPORTING GUIDELINES

Line No.	ACCOUNT	ACTUAL FYE 19___	ACUTAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
63	GENERAL AND ADMINISTRATIVE							
64	Salaries and Wages							
65	Administrator							
66	Assistant Administrator							
67	Administrator In-Training							
68	Other							
69	TOTAL SALARIES							
70								
71	Admin., Asst. Admin.,Admin.in-Train Fringe Benefits							
72	Admin,Asst. Admin.,Admin. in-Train Payroll Taxes							
73	Other Fringe Benefits							
74	Other Payroll Taxes							
75	Admin. Supplies							
76	PURCHASED SERVICES							
77	Administrator							
78	Assistant Administrator							
79	Administrator In-Training							
80	Ward Clerks							
81	Medical Records							
82	Accounting/Bookkeeping							
83	Legal							
84	Other							
85	TOTAL PUSRCHASED SERVICES							
86								
87	Allocated Expenses							
88								
89	Management Fees							
90	Travel							
91	Telephone							
92	Dues and Subscriptions							
93	Education & In-Service Training							
94	Insurance							
95								

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES
ADMINISTRATION AND OPERATIONS EXPENSES (in 000's)
(NURSING HOME OPERATION ONLY)
*AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS
FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL* FYE 19___	ACTUAL* FYE 19___	ACTUAL* FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
96	Miscellaneous Taxes							
97	Start-up/Organization Costs							
98	Advertising							
99	Other Vehicle							
100	Nursing Supplies							
101	Group retro expenses							
102	Office Equipment Lease Payments							
103								
104	Other							
105	TOTAL GENERAL AND ADMINISTRATIVE (lines 69 through 104, less line 85)							

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES - ADMINISTRATION AND OPERATIONS EXPENSES - (in 000's)

(NURSING HOME OPERATIONS ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
106	MAINTENANCE							
107	Salaries and Wages							
108	Fringe Benefits							
109	Supplies/Other							
110	Purchased Services							
111	Allocated Expenses							
112	Payroll Taxes							
113	TOTAL MAINTENANCE							
114	LAUNDRY							
115	Salaries and Wages							
116	Fringe Benefits							
117	Supplies/Other							
118	Purchased Services							
119	Allocated Expenses							
120	Payroll Taxes							
121	TOTAL LAUNDRY							
122	HOUSEKEEPING							
123	Salaries and Wages							
124	Fringe Benefits							
125	Supplies/Other							
126	Purchased Services							
127	Allocated Expenses							
128	Payroll Taxes							
129	TOTAL HOUSEKEEPING							
130	DIETARY							
131	Salaries and Wages							
132	Fringe Benefits							
133	Supplies/Other							
134	Purchased Services							
135	Allocated Expenses							
136	Payroll Taxes							
137	TOTAL DIETARY							
138	OTHER PROPERTY							
139	Utilities							
140	Property Insurance							
141	Real Estate Taxes							
142	Personal Property Taxes							
143	Allocated Expenses							
144	Minor Equipment							
145	Other							
146	Incidental Rentals							
147	TOTAL OTHER PROPERTY							
148	REVENUE OFFSET	(_____)	(_____)	(_____)	(_____)	(_____)	(_____)	(_____)
149								
150	TOTAL ADMINISTRATION & OPERATIONS							
151	(Lines 105+113+121+129+137+147+148)							

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES
PROPERTY EXPENSES (in 000's)
(NURSING HOME OPERATION ONLY)
AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS
FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
152	DEPRECIATION							
153	Land Improvements							
154	Buildings							
155	Building Improvements							
156	Equipment							
157	Leasehold Improvements							
158	TOTAL DEPRECIATION							
159								
160	INTEREST							
161	ALLOCATED EXPENSES							
162	LEASE PAYMENTS							
163	Lease Payment-Land							
164	Lease Payment-Building							
165	Lease Payment-Equipment							
166	TOTAL LEASE PAYMENTS							
167								
168	REVENUE OFFSET	( )	( )	( )	( )	( )	( )	( )
169								
170	TOTAL PROPERTY (lines 158 + 161 + 168)							
171	TOTAL ROUTINE EXPENSES (lines 57 + 62 + 150 + 170)							

September 1989

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES

OTHER PATIENT EXPENSES (in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

Name of Facility _____ FOLLOWING AASA REPORTING GUIDELINES

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
172	EXCEPTIONAL CARE							
173	Salaries & Wages							
174	Fringe Benefits							
175	Payroll Taxes							
176	Supplies/Other							
177	Purchased Services							
178	Allocated Expenses							
179	TOTAL							
180	(SPECIFY)							
181	Salaries & Wages							
182	Fringe Benefits							
183	Payroll Taxes							
184	Supplies/Other							
185	Purchased Services							
186	Allocated Expenses							
187	TOTAL							
188								
189	(SPECIFY)							
190	Salaries & Wages							
191	Fringe Benefits							
192	Payroll Taxes							
193	Supplies/Other							
194	Purchased Services							
195	Allocated Expenses							
196	TOTAL							
197								
198	(SPECIFY)							
199								
200								
201								
202								
203								
204								
205								
206								
207								
208	TOTAL (199-207)							
209	TOTAL OTHER PATIENT EXPENSES (Lines 179 + 187 + 196 + 208)							

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES

OTHER OPERATING EXPENSES (UNALLOWABLE)- (in 000's)

(NURSING HOME OPERATION ONLY)

AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS

Name of Facility _____ FOLLOWING AASA REPORTING GUIDELINES

Line No.	ACCOUNT	ACTUAL FYE 19___	ACTUAL FYE 19___	ACTUAL FYE 19___	CURRENT FYE 19___	NON-INFLATED DOLLARS PROJECTED FYE 19___	PROJECTED FYE 19___	PROJECTED FYE 19___
210	(SPECIFY)							
211	Salaries & Wages							
212	Fringe Benefits							
213	Payroll Taxes							
214	Supplies/Other							
215	Purchased Services							
216	Allocated Expenses							
217	TOTAL							
218								
219	(SPECIFY)							
220	Salaries & Wages							
221	Fringe Benefits							
222	Supplies/Other							
223	Purchased Services							
224	Allocated Expenses							
225	Payroll Taxes							
226	TOTAL							
227	OTHER UNALLOWABLE EXPENSES							
228	Admin. Compensation over Ceiling							
229	Management Fees over Ceiling							
230	Unallowable Depreciation							
231	Unallowable Bad Debts							
232	Unallowable Advertising							
233	Unallowable Travel							
234	Unallowable Interest							
235	Unallowable Allocated Property							
236	Unallowable Lease Payment							
237	Other (Specify)							
238								
239								
240								
241								
242								
243	TOTAL (Lines 256-281)							
244	TOTAL OTHER OPERATING EXPENSES (UNALLOW) (Lines 217 + 226 + 243)							

September 1989

SCHEDULE G - ITEMIZED LIST OF REVENUE AND EXPENSES
OTHER OPERATING EXPENSES (UNALLOWABLE)
NON-OPERATING EXPENSES (UNALLOWABLE) - (In 000's)
(NURSING HOME OPERATION ONLY)
AMOUNTS ENTERED SHOULD REFLECT ADJUSTMENTS/RECLASSIFICATIONS
FOLLOWING AASA REPORTING GUIDELINES

Name of Facility _____

Line No.	ACCOUNT	ACTUAL FYE 19____	ACTUAL FYE 19____	ACTUAL FYE 19____	CURRENT FYE 19____	NON-INFLATED DOLLARS PROJECTED FYE 19____	PROJECTED FYE 19____	PROJECTED FYE 19____
245	LOSS ON SALE OF FIXED ASSETS							
246	INCOME TAX							
247	OTHER (Specify)_____							
248								
249								
250								
251	TOTAL NON-OPERATING EXPENSES (UNALLOWABLE)							
252	TOTAL EXPENSES (Lines 171+209+244+251)							
253	NET INCOME (loss)							

April 1989

SCHEDULE H

DEBT INFORMATION FOR CURRENT FISCAL YEAR 19___

Name of Facility _____ (NURSING HOME OPERATION ONLY) Page 1 of 1

Line No.	DATE OF LOAN	LENDER	PURPOSE AND SECURITY	ORIGINAL TERM OF LOAN	ANNUAL INTEREST RATE	ORIGINAL LOAN AMOUNT	LOAN BALANCE AS OF THE END OF PRIOR YEAR	REPORT PERIOD PAYMENTS PRINCIPAL	REPORT PERIOD PAYMENTS INTEREST	BALANCE PER FINANCIAL STATEMENT
DEBT WITH BALANCE OVER $5,000 AT THE END OF REPORT PERIOD										
1										
2										
3										
4										
5										
6										
7										
8										
TOTAL OF ALL INDIVIDUAL DEBT UNDER $5,000 AT THE END OF REPORT PERIOD										
9										

April 1989

SCHEDULE K

BOOK VALUE OF ALLOWABLE ASSETS

(NURSING HOME OPERATION ONLY)

Name of Facility _____ Page 1 of 1

Line No.	ACCOUNT	LAST REPORTED FISCAL YEAR 19_____ ALLOWABLE ASSETS	ALLOWABLE ACCUMULATED DEPRECIATION	YEAR END BOOK VALUE
1	LAND			
2	LAND IMPROVEMENT			
3	BUILDING			
4	BUILDING IMPROVEMENT			
5	FIXED EQUIPMENT			
6	MOVEABLE EQUIPMENT			
7	VEHICLES			
8	OTHER EQUIPMENT			
9	TOTAL EQUIPMENT			
10	LEASEHOLD IMPROVEMENTS			
11				
12				
13				
14	TOTAL BOOK VALUE OF ALLOWABLE ASSETS			

April 1989

DEBT SERVICE CASH FLOW SCHEDULE

	SOURCE OF FUNDS								USE OF FUNDS							
	DEPRECIATION			AMORTIZATION		DONATIONS	OTHER SPECIFY	TOTAL FUNDS	PRINCIPAL PAYMENT	INTEREST PAYMENT	LAND PURCHASE	EQUIPMENT PURCHASE	TOTAL PAYMENTS	CASH EXCESS (SHORTAGE) AFTER USE OF FUNDS	ADDITIONAL FUNDS FROM INVESTED CASH	ANNUAL CASH EXCESS
YR	BUILDING STRUCTURE	BUILDING SERVICE EQUIPMENT	MOVABLE EQUIPMENT	FINANCE & LEGAL FEES	PREOPENING EXPENSES	OTHER SPECIFY										
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																
16																
17																
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20																
21																
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23																
24																
25																
26																
27																
28																
29																
30																

DEBT SERVICE CASH FLOW SCHEDULE

	SOURCE OF FUNDS								USE OF FUNDS							
	DEPRECIATION			AMORTIZATION		DONATIONS	OTHER SPECIFY	TOTAL FUNDS	PRINCIPAL PAYMENT	INTEREST PAYMENT	LAND PURCHASE	EQUIPMENT PURCHASE	TOTAL PAYMENTS	CASH EXCESS (SHORTAGE) AFTER USE OF FUNDS	ADDITIONAL FUNDS FROM INVESTED CASH	ANNUAL CASH EXCESS
AR	BUILDING STRUCTURE	BUILDING SERVICE EQUIPMENT	MOVABLE EQUIPMENT	FINANCE & LEGAL FEES	PREOPENING EXPENSES	OTHER SPECIFY										
31																
32																
33																
34																
35																
36																
37																
38																
39																
40																
41																
42																
43																
44																
45																
OTAL																

INSTRUCTIONS FOR COMPLETION OF FINANCIAL RATIO INFORMATION ALL FOR NURSING HOME PROJECTS

Utilizing the data from the fincancial statements submitted in the applicataion, calculate the Debt Service Coverage, Current Ratio, Assets Financed by Liabilities Ratio, and the Total Operating Expense to Total Operating Revenue Ratio. The method of calcuating these ratios is listed below. Enter the ratio figures in the table on the next page. The normal or expected value for each of these ratios is: Debt Service Ratio 1.5 - 2.0; Current Ratio 1.8 - 2.5; Assets Financed by Liabilities Ratio 0.6 - 0.8; and Total Operating Expense to Total Operating Revenue Ratio 1.0. If the project's calculated ratios are outside the normal or expected range, please explain

METHOD FOR CALCULATING FINANCIAL RATIOS

For each financial or calendar year, as appropriate, calculate the Current Ratio, the Assets Financed by Liabilities Ratio, the Total Operating Expense to Total Operating Revenue Ratio and the Debt Service Coverage Ratio:

RATIO	CALCULATION	LINE ITEMS
Current Ratio	Current Assets / Current Liabilities	Schedule B, Line 14 / Schedule B, Line 50
Assets Financed by Liabilities	(Current Liabilities + Long Term Liabilities) / Total Assets	Schedule B, Line 50 + 60 / Schedule B, Line 39
Total Operating Expense to Total Operating Revenue	Total Operating Expense / Net Operating Revenue	Schedule C, Line 22 / Schedule C, Line 9
Debt Service Coverage	(Net Income + Interest Expense + Depreciation Expense) / (Current Portion of Long-Term Debt + Interest Expense)	Schedule C, Line 28 + Schedule G, Line 160 + 158 / Schedule B, Line 44 + Schedule G, Line 160

Financial Ratios

Ratio	Actual FYE 19	Actual FYE 19	Actual FYE 19	Current Yr.Estim. FYE 19	Proj. FYE 19	Proj. FYE 19	Proj. FYE 19	Proj. FYE 19	Proj. FYE 19
Current Ratio									
Assets Financed by Liabilities									
Total Operating Expense/Total Operating Revenue									
Debt Service Coverage									